BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: JARETH S., Claimant, and SAN GABRIEL/POMONA REGIONAL CENTER, Service Agency.	OAH Nos. 2010110042 and 2011020606

DECISION

Administrative Law Judge Ralph B. Dash heard this matter on July 18, 2011 at Pomona, California.

Barbara Chen, Ed.D., represented Jareth S. (Claimant), who was present at the hearing.

Daniela Martinez, Fair Hearing Program Manager, represented San Gabriel/Pomona Regional Center (SGPRC or Service Agency).

ISSUE

The parties agreed the issue to be resolved is whether Claimant is eligible for services from the Service Agency.

FACTUAL FINDINGS

1. Claimant is 18 years old (date of birth December 15, 1992). He resides at Hathaway-Sycamores (Hathaway), a residential non-public school in Altadena, California. His qualifying diagnoses for the special education services offered at Hathaway are schizoaffective disorder, bipolar disorder, and post-traumatic stress disorder. He is soon to be emancipated and Hathaway personnel are making arrangements for him to be placed in a mental health board-and-care facility.

2. Academically, Claimant performs at the second-grade level. His I.Q. has been measured below 70 four times over the past four years (scores of 64, 65, 68 and 69), meaning that, based on measured I.Q., he is in the mentally retarded range. Those who have administered the I.Q. tests have opined that, based on scattered results in the I.Q subtests, Claimant's true I.Q. is in the borderline range. Service Agency agrees that Claimant "functions as a person with mental retardation and of course needs help" but has denied him services contending Claimant's deficit are caused by his psychiatric condition.

3. Hathaway psychologist Rochelle Lee evaluated Claimant in 2006 (Exhibit 2). She determined that Claimant has dual diagnoses, that is, a diagnosis on both Axis I and Axis II.[1] Her report reads, in part:

> [Claimant] has a complex psychiatric history including trauma and abuse, auditory and visual hallucinations, psychiatric hospitalizations and cognitive delays. . . .
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> [¶] . . . [¶]
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> Based on a standardized psychometric measure of intellectual functioning on which [Claimant] obtained an overall score of 68, his *overall* abilities are estimated to be in the extremely low range when compared to native-born English-speaking children his age on which the test was standardized (WISC-IV Full Scale IQ, 2nd %ile). The Full Scale IQ score is a composite of his performance in four domains: Verbal Comprehension, Perceptual Reasoning, Working Memory and Processing Speed, and is typically considered to be the most representative of general intellectual functioning. However, [his] cognitive functioning is best understood by considering his separate composite indexes, given the discrepancy among his abilities. [Claimant's] Verbal Comprehension Index, which is a measure of verbal concept formation, verbal reasoning

[1] The multiaxial system in common use places clinical syndromes on Axis I, developmental disorders on Axis II, physical disorders and conditions on Axis III, severity of psychosocial stressors on Axis IV, and global assessment of functioning on Axis V.

and knowledge acquired from one's environment, and his Perceptual Reasoning Index, which is a measure of perceptual and fluid reasoning, spatial processing and visual-motor integration, were within the low average and borderline ranges, respectively. His verbal and non-verbal skills were found to be better developed than his full scale IQ represents. . . .

[¶] . . . [¶]

Regarding [his] intellectual functioning, [Claimant] was found to possess delays across cognitive domains including verbal and non-verbal reasoning, learning and memory, and rate of information processing. It is suspected that his significant delays in visual processing/processing speed depressed his overall full scale intelligent (*sic*) quotient. [Claimant's] **Borderline Intellectual Functioning** will, therefore, make him a more challenging psychotherapy client.

Adolescents with both mood disorders and cognitive delays present a unique set of treatment considerations. . . . Assessment procedures need to be modified by focusing on physiological signs and behavioral equivalents to subjective states. It is recommended that behavioral modification techniques be employed to teach [Claimant] appropriate behaviors and skills . . . . More specifically, it is recommended that specific behaviors are targeted through functional analysis, in order to determine the purposes that they serve and the reinforcement that they achieve. For example, teaching functional skills to target aggressive behavior and social skills is recommended . . . .
(Emphasis in original.)

4. Clinical psychologist Gabrielle du Verglas evaluated Claimant in May 2008 (Exhibit 4). Her testing, using the same intelligence test (Wechsler Intelligence Scale for Children-Fourth Edition, commonly referred to as WISC-IV), yielded virtually identical results for Claimant as those obtained by Dr. Lee. With respect to Claimant's adaptive functioning, Dr. du Verglas made the following observations:

Adaptive functioning was assessed with the Adaptive Behavior Assessment System-Second Edition (ABAS-II) with his house staff serving as informant. The [ABAS-II] is a measure of adaptive functioning assessing ten separate areas: Communication, Community Use, Functional Pre-Academics, Home Living, Health and Safety, Leisure, Self-Care, Self-Direction, Social and Motor Skills Areas. In addition, a Global Adaptive Composite measures overall adaptive level, while Conceptual, Social and Practical Domain Composites are also established.

> On this measure, [Claimant's] Composite Score was 59, Conceptual Adaptive Domain Score 63, Social Adaptive Domain Score 72 and Practical Adaptive Domain Score 54. With the exception of his Social Adaptive Domain score, which was in the borderline range, all scores were in the extremely low range of abilities.

5. Testimony at hearing from Claimant's care providers confirmed Dr. du Veglas' ABAS II test results. Claimant was described as a "loving child in a man's body." He will go up to strangers and hug them. He needs constant prompts and one-on-one aides to help him with daily living skills, including basic hygiene, selecting appropriate clothing for the weather, money management (he does not count change received after a purchase), diet control, engaging in age appropriate activities, making his bed, cooking even the simplest of meals, street safety and virtually all other "life skills."

6. In August 2010, Claimant was evaluated by Hathaway psychologist Jennie Mathess (Exhibit 5). As in the previously described evaluations, Dr. Mathess found dual diagnoses for Claimant, with Axis I being schizoaffective disorder, among others, and Axis II being borderline intellectual functioning. In her report, Dr. Mathess noted the following:

> [Cognitive] testing indicates [Claiamant's] overall intellectual functioning is in the extremely low range. His difficulties remaining focused and the internal and external distractibility he seemed to experience may have lowered his scores somewhat. As such, it is likely that his true cognitive abilities are actually in the *low borderline range*, reflecting **Borderline Intellectual Functioning**. This level of functioning reflects difficulties with verbal and nonverbal reasoning, abstraction, working memory and processing speed. It should also be noted that [Claimant] demonstrates *significant deficits in adaptive functioning*, as evidenced by reports from residential staff, testing completed by [Claimant], as well as the Vineland-II [which showed an adaptive functioning composite of 54, which is more than three standard deviations below the norm]. More specifically, he exhibits deficits in the areas of self-care, social skills, self-direction, functional academic skills, communication, as well as the capacity for independent living and economic self-sufficiency. By report, his difficulties in this regard have been longstanding. While his cognitive functioning is low borderline, it is this examiner's opinion that [Claimant] is actually ***functioning in a manner that is similar to that of a person with mental retardation.*** While one may argue that [Claimant's] present level of functioning is best attributed to his history of mental illness, test data suggests (*sic*) developmental problems that have likely been more long-standing than his present mental illness. His academic and functional academic skills are well below age and grade level, consistent with those of a second grade student, despite receiving special education

services for numerous years. In addition, even when [Claimant's] mental illness is best controlled by medications and the therapeutic milieu, he continues to struggle with adaptive skills and independent living. (Emphasis in original.)

7. Psychiatrist Lisa Acosta, M.D., has treated Claimant for three and one-half years and testified at the hearing. She too has diagnosed Claimant with both schizoaffective disorder and borderline intellectual functioning. Dr. Acosta was quite clear in her testimony that Respondent's cognitive deficits could not be accounted for solely by his psychiatric issues. Dr. Acosta noted that mental retardation and borderline intellectual functioning manifest themselves before psychiatric problems become evident. She further testified that this was true in Claimant's case, as evidenced by Claimant's history of being a "slow" child and having had special education since he was in kindergarten, before any psychiatric problems manifested themselves.

8. Nick Ryan is a Marriage and Family Therapist who is the clinical director at Hathaway. He is Claimant's therapist and has known him since 2008. He testified that Claimant has been receiving therapy for mental health issues primarily because "Hathaway is a mental health facility." Mr. Ryan has had other clients with schizophrenia, but without the dual diagnosis of borderline personality, who have cognitive abilities much higher than those of Claimant.[2] He stated that medications are not the cause of Claimant's deficits. While the medications manifest some adverse effect, such as facial tics, they do not prevent Claimant from learning. He simply does not have the capacity to learn. Mr. Ryan further noted that even with constant re-direction, Claimant cannot learn the simplest of tasks and that even when Claimant does learn a particular skill, he cannot translate that into performing other tasks which require the same skill.

9. Psychologist Lisa M. Doi evaluated Claimant on behalf of SGPRC on December 15, 2010, Claimant's 18th birthday. Dr. Doi administered a full battery of tests, including the Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV) and the ABAS-II. Claimant achieved a full scale IQ of 69 on the WAIS-IV. His composite score on the ABAS-II was 47. Dr. Doi also gave Claimant dual diagnoses, schizoaffective disorder and borderline intellectual functioning. Dr. Doi did not opine that Claimant's cognitive deficits were due solely to his psychiatric condition. In fact, Dr. Doi told SGPRC psychologist Deborah Langenbacher that Claimant's deficits were "primarily," not "solely," psychiatric in nature. Dr. Langenbacher did not evaluate Claimant, but did review all of the testing and reports noted above. She believed that

[2] In a similar vein, Robert Kopf, Hathaway mental health rehabilitation specialist, testified that he has numerous clients with significant psychiatric problems, but not with borderline intelligence, who function at a much higher level than Claimant.

Claimant's deficits were caused by his psychiatric problems, but even she did not testify that his deficits were caused "solely" by his mental condition.[3]

10. Maura Flaherty, M.A., Director of Hathaway, wrote a letter, dated July 11, 2011 (Exhibit F), on Claimant's behalf. In that letter, Ms. Flaherty left no doubt as to Claimant's cognitive deficits and his need for services. She wrote, in part:

> [C]lassroom staff and academic achievement assessors have documented that [Claimant's] skill deficits are not performance deficits due to factors such as physical limitations, psychiatric conditions, socio-cultural deprivation, poor motivation, substance abuse or limited experience. It is the school's belief based on data that [he] requires significant, consistent training and supports to develop functional skills rather than needing treatment to increase motivation. [He] has always wanted to be successful with his learning and to do his best and has always given complete effort to his assigned task. It is the school's belief that this training and support needs to be long-term and over his entire life in need.
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> In addition to [Claimant's]significant subaverage academic functioning, [he] has demonstrated over his 4+ years with us substantial adaptive deficits clearly related to his obvious cognitive limitations. [His] significant deficits in adaptive skills have been demonstrated over all of his years with us and to a marked degree in the areas of learning, self-care, self-direction, capacity for independent living and economic self-sufficiency.

LEGAL CONCLUSIONS

1. Claimant has established that he suffers from a developmental disability entitling him to regional center services. (Factual Findings 2 through 10.)

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code, §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is referred to as an appeal of the Service Agency's decision. Where a claimant seeks to establish eligibility for services, the burden is on the appealing

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[3] In any event, because Dr. Langenbacher did not personally test and interview Claimant, her testimony is given less weight than the evidence presented by other experts who had tested/interviewed Claimant. (See *People v. Bassett* (1968) 69 Cal.2d 122, 141.)

claimant to demonstrate that the Service Agency's decision is incorrect. Claimant has met his burden of proof in this case.

3. In order to be eligible for regional center services, a claimant must have a qualifying developmental disability. Welfare and Institutions Code section 4512, subdivision (a) defines "developmental disability" as:

> a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, and includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

4(a). To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must show that he has a "substantial disability."

4(b). California Code of Regulations, title 17, section 54001 states, in pertinent part:

> (a) "Substantial disability" means:
> (1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and
> (2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:
> (A) Receptive and expressive language;
> (B) Learning;
> (C) Self-care;
> (D) Mobility;
> (E) Self-direction;
> (F) Capacity for independent living;
> (G) Economic self-sufficiency.

5(a). In addition to proving a "substantial disability," a claimant must show that his disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: mental retardation, epilepsy, autism and cerebral palsy. The fifth and last category of

eligibility is listed as "Disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation." (Welf. & Inst. Code, § 4512.) This category is not further defined by statute or regulation.

5(b). Whereas the first four categories of eligibility are very specific, the disabling conditions under this residual, fifth category are intentionally broad to encompass unspecified conditions and disorders. However, this broad language is not intended to be a catchall, requiring unlimited access for all persons with some form of learning or behavioral disability. There are many persons with sub-average functioning and impaired adaptive behavior; under the Lanterman Act, the Service Agency does not have a duty to serve all of them.

5(c). While the Legislature did not define the fifth category, it did require that the qualifying condition be "closely related" (Welf. & Inst. Code, § 4512, subd. (a)) or "similar" (Cal. Code. Regs., tit. 17, § 54000) to mental retardation or "require treatment similar to that required for mentally retarded individuals." (Welf. & Inst. Code, § 4512, subd. (a).) The definitive characteristics of mental retardation include a significant degree of cognitive and adaptive deficits. Thus, to be "closely related" or "similar" to mental retardation, there must be a manifestation of cognitive and/or adaptive deficits which render that individual's disability like that of a person with mental retardation. However, this does not require strict replication of all of the cognitive and adaptive criteria typically utilized when establishing eligibility due to mental retardation (e.g., reliance on I.Q. scores). If this were so, the fifth category would be redundant. Eligibility under this category requires an analysis of the quality of a claimant's cognitive and adaptive functioning and a determination of whether the effect on his performance renders him like a person with mental retardation. Furthermore, determining whether a claimant's condition "requires treatment similar to that required for mentally retarded individuals" is not a simple exercise of enumerating the services provided and finding that a claimant would benefit from them. Many people could benefit from the types of services offered by regional centers (e.g., counseling, vocational training or living skills training). The criterion is not whether someone would benefit. Rather, it is whether someone's condition <u>requires</u> such treatment.

6. Claimant's intellectual functioning cannot be determined with complete specificity. His various IQ tests have placed him in the range of mild mental retardation, borderline intelligence, and even on one part of one test, low average intelligence. However, as noted above, IQ alone does not determine whether an individual is mentally retarded. One must also look at the Claimant's adaptive functioning. As set forth in CCR section 54001, subdivision (b), because an individual's cognitive and/or social functioning are many-faceted, there are at least seven categories relative to adaptive functioning that must be examined. These categories are the same or similar to the categories of adaptive functioning skills listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,

Text Revised (DSM-IV-TR) that, to support a diagnosis of mental retardation, requires a finding of significant limitations in at least two such skills. Applying the evidence to the seven listed categories reveals the following:

(1) Communication skills: Claimant's communication skills problems, by themselves, are neither severe enough nor sufficiently impairing to constitute a developmental disability. There was no evidence presented that Claimant did not know the meaning of ordinary words, nor that he could not use those words appropriately.

(2) Learning: The evidence shows Claimant is severely impaired in his ability to learn.

(3) Self-care: Claimant's ability to take care of himself is severely impaired. He cannot perform the activities of daily living, including the simple act of dressing appropriately for the weather.

(4) Mobility: Claimant's mobility is impaired in that he cannot use public transportation at all without assistance.

(5) Self-direction: Claimant has no self direction, and cannot plan, organize or accomplish even simple tasks without direction, prompting and supervision.

(6) Capacity for independent living: Claimant cannot live independently, nor is he likely ever to be able to live independently.

(7) Economic self-sufficiency: Claimant has no skills or abilities to perform any marketable menial or manual labor service.

7. Over and over again, it was established that Claimant has major impairments in cognitive and social functioning. He cannot function independently in a variety of settings. On a cognitive level, he has difficulty learning from his experiences, solving problems, and adapting to new situations. He also suffers from poor judgment and memory. He cannot be gainfully employed. He does not possess essential skills to live alone. He cannot pay bills, plan meals, shop, or prepare even simple foods without direction. He cannot use public transportation. He does not know what to do in the event of injuries and emergencies. He cannot manage his money. He does not have the skills to develop social relationships. He cannot even attend to his own personal hygiene. Thus, based on all of the evidence as set forth above, it is determined that Claimant suffers from a condition that is similar to mental retardation.

8. In order to establish eligibility, a claimant's substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, § 4512, and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are solely physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely psychiatric disorders or solely learning disabilities. Therefore, a person with a "dual diagnosis," that is, a developmental disability coupled with a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originate only from the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination) and who does not have a developmental disability, would not be eligible.

9. The DSM-IV-TR describes mental retardation as follows:

> The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.
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> *General intellectual functioning* is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children—Revised, Stanford-Binet, Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ,

> will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.
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> Impairments in adaptive functioning, rather than a low IQ are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

(DSM-IV-TR at pp. 39 - 42.)

10. Regarding mild mental retardation (I.Q. level of 50-55 to approximately 70), the DSM-IV-TR states:

> [Persons with mild mental retardation] typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. By their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

(*Id*. at pp. 42 - 43

11. Regarding the differential diagnosis of Borderline Intellectual Functioning (IQ level generally 71 to 84), the DSM-IV-TR states:

> Borderline Intellectual Functioning describes an IQ range that is higher than that for Mental Retardation (generally 71-84). As discussed earlier, an IQ score may involve a measurement error of approximately 5 points, depending on the testing instrument. Thus, it is possible to diagnose Mental Retardation in individuals with IQ scores between 71 and 75 if they have significant deficits in adaptive behavior that meet the criteria for Mental Retardation. Differentiating Mild Mental Retardation from Borderline Intellectual Functioning requires careful consideration of all available information.

(*Id*. at p. 48.)

12. Claimant does not meet all the criteria under the DSM-IV-TR for a diagnosis of mental retardation. However, Claimant does demonstrate borderline intellectual functioning together with deficits in cognitive functioning and deficits in adaptive functioning in the areas of communication, use of community resources, self-direction, and functional academic skills. The totality of the evidence established that Claimant suffers from a condition similar to mental retardation. The evidence also established that Claimant requires treatment similar to that required for mentally retarded individuals. He requires long term training, with steps broken down into small discrete units taught through repetition. Additionally, as with persons with mental retardation, Claimant requires supports across many skill areas.

13 Based upon the evidence presented, Claimant has met his burden of proof that he has a substantial disability as defined by Welfare and Institutions Code section 4512, and California Code of Regulations, title 17, section 54001. Claimant suffers from impairment of cognitive and social functioning, as well as significant functional limitations in receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living and economic self-sufficiency.

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14. The weight of the evidence supports a finding that Claimant is eligible to receive regional center services. These deficits are not caused solely by his psychiatric condition.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The Service Agency's determination that Claimant is not eligible for regional center services is overruled, and Claimant's appeal of that determination is granted. The Service Agency shall accept Claimant as a client forthwith.

DATED: July 20, 2011

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RALPH B. DASH
Administrative Law Judge
Office of Administrative Hearings

Notice:
This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.